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ABSTRACT

The literature on attitudes of health workers toward the elderly suggests three variables as contributing to the elderly patient's perception of helplessness in the health care setting. First, the health worker may age-stereotype the elderly person as dependent, low in competence, and unlikely to respond to treatment. Secondly, the disparity in status between the health professional and patient leads to interpersonal distance, and the "professional-patient role" reinforces submissive behavior on the part of the patient. Lastly, in conformity to the "sick role" the elder person may relinquish responsibility for his/her actions. The relative prevalence of chronic or disabling health conditions among the elderly make them most vulnerable to the helplessness-engendering conditions of the health care setting. (Author)

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SOCIAL ANTECEDENTS OF LEARNED HELPLESSNESS IN THE HEALTH CARE SETTING

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Older persons make greater use of health care services than do the remainder of the population. In part, this reflects a greater need for services on the basis of more frequent and lengthier episodes of acute illness, as well as the higher incidence and prevalence of chronic disorders requiring ongoing care in the elderly. Therefore, the elderly person is quite likely to come into frequent contact with many health care providers of different professions, including physicians, nurses, physical therapists, occupational therapists, etc.

The attitudes of these workers are extremely important in determining the type and quality of services received by the elderly. Negative attitudes may lead to inadequate, dehumanized care. Stereotyped attitudes may lead to a loss of the elderly person's inherent individuality, followed by inadequate or inappropriate care. Furthermore, the attitudes of health providers partly determine the responses of the older patient to specific health or sickness interventions, the older person's attitudes toward the health care setting in general, and his/her attitudes toward self-care, health maintenance, and rehabilitation.

Approximately 5% of the elderly are institutionalized at any given time in the United States (Redick, Kramer, & Taube, 1973). These one million people have 24 hour-a-day contact with health care providers. The attitudes of these providers and the attitudes toward rehabilitation of the chronically dysfunctional elderly adult set the stage for determining the old person's self-concept and attitudes toward his/herown care and the development of institutionalized behavior and related social breakdown syndrome. An analogous process also occurs in the millions of elderly patients who

are hospitalized each year for an acute medical problems.

Among the many effects of negative attitudes of health care providers is the development of behaviors that may result in learned helplessness, which will be the focus of this paper. These behaviors result not only from the attitudinal and affective interaction between the health care provider and the elderly patient, but also from a disparity in status that is in itself often a result of stereotyping. This is then reinforced by the maintenance of appropriate sick role behavior and the reinforcement of this sick role behavior on the part of the health care provider. This paper will examine the issues of stereotyping, disparity of status and social exchange, and the sick role as social antecedents to the development and maintenance of learned helplessness within health care institutions. The contribution of each to learned helplessness will be discussed and theoretical interfaces examined. The sick elderly will be the focus of this paper, although much of what will be discussed can be extrapolated to the well elderly.

LEARNED HELPLESSNESS

In Seligman's model of learned helplessness, (Seligman, 1975; Maier & Seligman, 1976) certain variables are necessarily present for the syndrome to develop. Some variables reflect the effect of social operants on response-outcome. Others reflect the individual contingencies that affect the perceptions and beliefs of the older person.

For learned helplessness to develop, response-outcome must be independent of subject response. Thus, regardless of the seeming appropriateness of the response to the subject's needs, the response is not reinforced by the environment. Furthermore, as it becomes clear that the subject has no control over response-outcome, the subject becomes apathetic and a "giving-up-given up" syndrome, similar to that discussed by Engel (1967), develops,

with apathy, lack of response, and helplessness as the consequence.

In addition, the individual may come to perceive response-outcome as not under his/her control, regardless of the reality of that perception. This perception colors any attempts at controlling one's responses, and may be believed as reality, again contributing to learned helplessness.

STEREOTYPES OF THE ELDERLY BY HEALTH WORKERS

Solomon and Vickers (in press) have defined a stereotype as "the holding in common by the members of a group of a standardized mental picture representing an oversimplified and uncritical judgment of another group." Given this definition, it can be said that, in general, the acceptance of stereotypes of the elderly by health care providers is not any different from that of the general population. The data in support of the opposite idea, that health care providers are less willing to accept the stereotype of old people, is limited and non-specific. For example, Rosencranz and McNevin (1969) found that stereotyping was less characteristic of professional and economically advantaged classes; this finding was confirmed by Ivester and King (1977). Thorson, Whatley, and Hancock (1974) and Thorson (1975) showed that with more years of education, a more realistic set of expectations was held of the aging. In all of these studies, health care providers were not specifically evaluated.

Most of the published data supports the concept that older people are stereotyped as frequently by health care providers as by other members of the population. This literature will be briefly reviewed. LeShan and LeShan (1961), Kastenbaum (1963), and Garfinkle (1975) have all stated that psychotherapists are reluctant to work with older people because of these stereotyped therapists' unexamined values that determine who is to receive therapy. In other words, old people are generally not considered capable of growth, independence, and autonomy.

Tuckman and Lorge (1958) found that older individuals who had previous experience with the aged and who took a lecture course on the elderly accepted the stereotypes of old people to the same degree as students who did not take such a course. Arnhoff and Lorge (1960) studied gerontology fellows, all of whom had an M.D. of Ph.D. degree, and found that this group had also accepted many of the stereotypes of old people to a similar degree as other population groups. They found that this group was more likely to advise palliative therapy than a growth-oriented therapy for older people.

McGuinness and Knox (1968) found that nursing students tended to rank psychogeriatric nursing either as their first or last choice of career. Interestingly enough, the reasons for first or last choice were similar: more bedside nursing, slow convalescence, and the dependency of the patients. This was found to be related in part to nursing students' stereotypes of old people.

Spence, Feigenbaum, Fitzgerald, and Roth (1968) evaluated the acceptance of stereotypes by freshman and senior medical students and found no difference between the two groups. They felt that this acceptance was a response both to societal stereotypes as well as to a medical training which emphasized the chronological age of the patient. Mills (1972) found that undergraduate occupational therapy students held to the stereotypes of old people and this prevented them from developing an interest in working with the geriatric population.

Cyrus-Lutz and Gaitz (1972) evaluated the attitudes of psychiatrists toward old people and found that although psychiatrists were more aware of the positive attributes of the elderly, such as their humanistic values, the importance of work, and their wisdom and intelligence, as well as their fears of loneliness and isolation, they tended to concentrate on negative aspects of aging, such as memory loss, physical problems, and psychiatric

symptomatology as more relevant to their role as a physician. In other words, these psychiatrists were not concentrating on those aspects of the older population that would allow for maximum utilization of therapeutic skills for their older patients. This, in turn, would lead to atrophy of the older patients' coping skills, which may lead to the development of dependency and learned helplessness, as will be discussed below.

Solomon and Vickers (in press) studied the acceptance of stereotypes of old people by medical students, housestaff, and geriatric team staff. They found that there were significant differences between these groups of health care professionals and that, in general, medical students and housestaff held to the stereotypes more strongly than geriatric staff. The stereotypes held by these students and housestaff were that older patients have limited activities and interests, were in poor physical condition, were not important to their family, had negative personality traits, were pessimistic toward the future, were insecure, developed mental and physical deterioration, and were asexual beings. On two items of the Tuckman-Lorge Questionnaire that are particularly related to stereotypes of helplessness, marked differences were noted between students, housestaff, and the staff of a mobile psychogeriatric team that emphasized independence, autonomy, and growth for clients (Table I).

Assuming that these stereotypes are some of the social antecedents of learned helplessness requires an assumption that stereotyping and attitudes are translated into behavior. Indeed, most people who have had any experience working in hospitals or nursing homes could probably give many examples of how health workers age-stereotype the elderly person in their behavior and the subsequent development of helpless behavior. Although this hypothesis is difficult to test, Simon and Wilson (1978) found that nurses who view patients as dependent and in need of care reinforced sick role,

psychopathological, and dependent behavior in their patients and negatively reinforced socially appropriate behavior. These data supplement the rich observations of Goffman (1961) on the creation of dependency among residents of total institutions.

How does this occur? By stereotyping the aged person as dependent, "senile," incompetent, and chronically disordered with poor prognosis, the health worker does not respond to the older person's behavior and needs but responds to the patient's custodial or maintenance needs, as perceived by the health worker. These perceptions are frequently different from the patient's own perceptions of his/her needs. The care provider's responses, which are not particularly rewarding or gratifying to the provider, become haphazard, artificially scheduled, or perhaps even non-existent. The older patient's individuality and individual needs become lost to the provider.

Some of the major elements of Seligman's theory (Seligman, 1975; Maier & Seligman, 1976) that was noted above may now be identified. The older person's responses to his/her own internal needs, whether they be hunger, thirst, pain, discomfort, or growth, not only does not lead to an appropriate response on the part of the caregivers, but actually may lead to inappropriate or no responses. On the other hand, the caregivers respond haphazardly and independently of the needs of the individual patient. Thus, response-outcome becomes uncontrolled by the older patient and independent of the older person's response to his/her own needs. This loss of control of response-outcome of his/her behavior eventually leads the older person to give up, with the development of a sense of helplessness.

The older person may also come to perceive that all that can be done for him/her is in the hands of the health worker who maintains total control of response-outcome. If the old person is in a total institution in which the staff is not only perceived to be in control, but in reality may control

every minute of the person's day, then it is possible that all behavioral responses to all stimuli become independent of response-outcome. Once the older person begins to behave in a way consistent with helplessness, the contingencies of his/her environment, i.e., the negative stereotyping of the health care provider coupled with the real effects of institutionalization, only serve to reinforce the helpless behavior. This further leads to a marked decrease in motivation, more dependency, and more helplessness. In an extreme, the older person may actually do nothing for him/herself. The end result is then a malodorous room of "senile" old persons, restrained in geri-chairs, incontinent of urine, not interacting with each other, apathetically staring at a television screen with a rolling picture, or mumbling to themselves.

EXCHANGE THEORY

Exchange theory hypothesizes that human interpersonal interaction is mediated by the real and perceived benefits and costs to individuals involved. As noted by Nye (1978), exchange theory involves both rational and irrational choices on the part of the participants of an interaction. It also involves certain propositions, several of which have some consequence for the development of learned helplessness in the elderly. For example, if an interpersonal interaction's long-term outcomes are perceived as equal, the individuals will choose alternatives providing better immediate outcomes. If costs are perceived as equal, the individuals will choose alternatives that will supply, or are perceived to supply the most rewards. Finally, if costs and other rewards are equal, individuals will choose the alternatives which can be expected to supply the most social approval or least social disapproval.

In the interactions between health care providers and elderly patients, interpersonal distance increases. Part of this distance is related to contingencies inherent in the sick and healer roles. Distance is further

increased with old patients because of other disparities of status on multiple strata of status, including education, age, roles, and to some degree, real helplessness. As Blau (1955) has noted, a differential in benefits and costs, coupled with increased distance, leads to a disparity in the distribution of power in the relationship, which increases the chance of capricious behavior on the part of the provider. Response-outcome may then become independent of behavior.

In addition to an increase in interpersonal distance, health care providers are faced with the situation in which they perceive long-term outcome as being generally negative and the costs to the provider in terms of both emotional and physical energy being high. Therefore, they are unlikely to invest much energy in order to minimize cost and maximize the few benefits that are perceived to be gained from working with the elderly. Thus, their behavior becomes responsive to their own needs to optimize their own "cost/benefit ratio," and may then become unresponsive to the needs of the elderly patient. This sets up a situation in which response-outcome becomes independent of the elderly patient's response to stimuli, which is one of the conditions necessary for the development of learned helplessness.

In addition, the health care provider who treats the elderly patient in a way inconsistent with stereotyping and who perceives working with the elderly as having long-term benefits at lesser costs than is perceived by his/her colleagues, can expect to meet with the disapproval of these colleagues. However, social approval is a powerful benefit for the health care worker. Thus, the society of peers, i.e., other physicians, nursing personnel, etc., through the use of stereotyping and social pressure, enforces a view of the interpersonal exchange with the sick elderly that becomes consistent with perceived minimization of cost and maximization of benefits by minimizing consistency and quality of response to the needs of

the elderly patient.

From the patient's point of view, the power disparity forces the patient to "play the game" by the provider's rules and to adapt to the behavior of the provider. If the patient is to benefit at all from the interaction, this becomes a necessity. Playing by the provider's rules also minimizes the costs in psychological energy in order to receive care, at least on a short-term basis. As old people are more likely to accept the stereotype of old people than any other population group (Tuckman & Lorge, 1953), their expectations of themselves are further minimized and allow them to accept the passivity and dependency necessary for care to be received, thus further minimizing costs while maximizing the short-term benefits. Unfortunately, much care is given on a long-term basis to old people, and, if the "rules of the game" are not changed, costs may be diminished to zero in order to gain any benefits that accrue from interactions with an uncontrollable and unpredictable environment.

THE SICK ROLE

Introduction of the concept of the sick role into the discussion of the social antecedents of learned helplessness also means the introduction of an important reality factor. The reality is that most older persons, when they become ill, do require some help from other people. The more serious the illness, the more complex and necessary the help. Thus, any sick individual is put into a social position in which helpless and dependent behavior is expected, sanctioned, and reinforced. Indeed, as Wilson (1970) points out, the adoption of the sick role results in the development of a mutuality of roles between the ill person and the healer. The sick role, as Parsons (1951) has noted, is legitimate behavior for the ill person who then has the societal responsibility to accept whatever help is offered by someone who is defined by society as a healer.

Thus, the sick person becomes a passive, dependent, and weak individual who is at the mercy of the medical skills and expertise of the healer. In order to get well, the sick person is completely dependent upon his/her interpersonal relationships with caregivers. In the ideal situation, the healer provides not only health, but support and permissiveness. In other words, the sick person is allowed to behave not according to the usual role behaviors of that person, but is granted permission to be socially regressed and is not expected to function to capacity or take full responsibility for his/her behavior, except health-seeking behavior.

However, the healer also manipulates rewards for appropriate sick role behavior. Within the context of the learned helplessness paradigm, the manipulation of rewards can mean that the person's needs will be appropriately responded to and that the response-outcome for elderly patients will be dependent upon and consistent with the response of that patient. However, because all the power is held by the healer, the healer's response and rewards may be totally independent of the patient's needs, leading to independence of response-outcome. This will serve to set up a situation where the older person perceives that he/she has no control over his/her health care or what is done to his/her body or mind. He/she then passively accepts whatever the healer says is to be done. Again, this is a two-edged sword. If the healer is attuned to a model of personal growth and autonomy, as well as the needs of the older patient, the responses of the healer may minimize the chance of learned helplessness developing. Instead, the older patient will gradually divest him/herself of the sick role and re-establish appropriate premorbid role behavior. However, if the healer functions according to stereotypes, negative attitudes, then perpetuation of the dependent, helpless role become inevitable. The healer's responses become unpredictable and independent of need, leading to further learned helplessness.

THEORETICAL INTERFACES

The interaction among these three theories is complex, as noted in Figure 1. Some interfaces have previously been noted. Other major interfaces will be discussed at this time. Firstly, negative stereotyping by health care providers may lead to the elderly patient being viewed as helpless, dependent, unproductive, weak, and powerless. Translating these attitudes into behavior means that the health worker will then treat the elderly person as helpless, dependent, weak, powerless, and vulnerable, a stereotype accepted by the elderly. The stereotype and behavior of the caregivers leads to minimal expectations of inner-directed behavior by the patient. The major danger of stereotyping and its resultant behavior, as has been pointed out by Solomon and Vickers (in press), is that there is a loss of awareness of the individual's needs so that services are given to the older patient regardless of their appropriateness. In other words, response-outcome becomes independent of response and this independence is perceived and expected, leading to helplessness.

The status differential between the health worker and the older patient that leads to interpersonal distance is accentuated by stereotypic behavior. The health worker who perceives minimal benefits and maximal costs with working with older patients, also holds a great deal of power over the older patient because of this distance. The health provider then reduces costs by spending less time with the older patient or behaving in a way as if the older person needs things done for him/her. Or the provider may maximize benefits by reducing prognostic expectations. The resultant behavior further increases distance and the disparity of power and thereby increases the chance of independence of response-outcome. The sick role with its passivity and helplessness, only serves to reinforce the stereotype of old people by the older person and gives the older person permission to relinquish

responsibility for his/her self-care behavior. The acceptance of the sick role has its benefits for the older person, at least during a period of illness, as it leads to a reciprocity of roles with the provider, at the cost of increasing the provider's power. Again, the system is maintained.

Finally, while these interactions may all occur in the context of an outpatient medical setting, more helplessness and depression is seen in the context of total institutions for the elderly, including mental hospitals, nursing homes, and acute care hospitals. Total institutions are considered that because they completely control all response contingencies of their residents' lives and therefore wield an almost omnipotent power over the lives of the elderly living in them. Thus, powerlessness and few expectations for growth and change further lead to the development of learned helplessness. In a total institution, learned helplessness in the elderly is probably more pervasive than seen anywhere else in the human social environment.

In order to prevent these processes from robbing our elderly patients of their autonomy and ability to attain personal growth regardless of functional or neurologic incapacity, both individual and societal interventions are necessary. In brief, they should include education of health workers in a setting that emphasizes a positive, growth-oriented context to the elderly. This approach was hypothesized by Cook (1962) and has been noted to be moderately successful in several studies (Hickey, Rakowski, Hultsch, & Fatula, 1976; Auerbach & Levinson, 1977; Solomon & Vickers, in press). Those health workers who do not subscribe to the stereotypes of the elderly (and it is sad to note that too many geriatricians and geriatric psychiatrists do accept these stereotypes) should be available for educational and consulting work with individual elderly patients, families, agencies, and total institutions. An individual patient's psychotherapy should include an emphasis on

developing mastery of the older person's environment, growth, and autonomy. Work with staff at institutions should emphasize demythologizing and the development of changed and more positive nonstereotyped attitudes toward old people. Finally, changes in the structure of society that the author has discussed elsewhere (Solomon, 1978) are necessary to change the stereotypes and how they develop so that the elderly in the United States are no longer seen as objects of vulnerability, dependency, and helplessness.

TABLE I

ATTITUDES OF HOUSESTAFF, MEDICAL STUDENTS, AND GERIATRIC STAFF

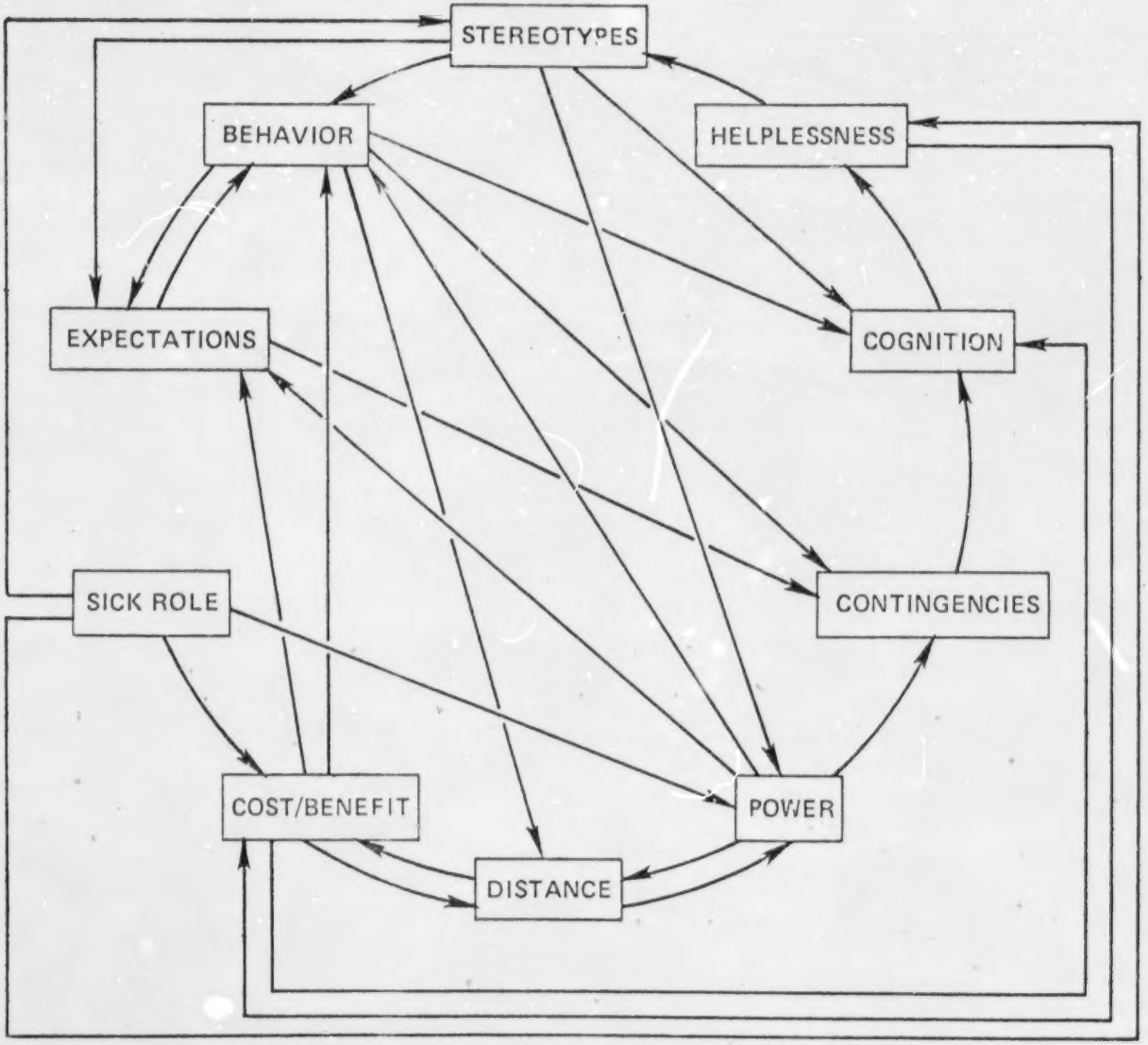
Item 52. They like to be helped across the street

	Yes	No		
Housestaff	30%	70%	$X^2 = 6.28$	$p < .02$
Geriatric Staff	8%	92%		

Item 75. They like to be waited on.

	Yes	No		
Housestaff	33%	67%	$X^2 = 11.44$	$p < .001$
Geriatric Staff	3%	97%		
Medical Students	29%	71%	$X^2 = 10.77$	$p < .01$
Geriatric Staff	3%	97%		

FIGURE I - THEORETICAL INTERFACES



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